Filing at a Glance

Company:	Sentry Life Insurance Company
Product Name:	Group Dental, Disability Income and Life Application
State:	Arkansas
TOI:	ML02 Multi-Line - Other
Sub-TOI:	ML02.000 Multi-Line - Other
Filing Type:	Form
Date Submitted:	07/23/2012
SERFF Tr Num:	SLIN-128589289
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	
Implementation Date Requested:	On Approval
Author(s):	Linda Pawlowski
Reviewer(s):	Donna Lambert (primary)
Disposition Date:	07/23/2012
Disposition Status:	Approved
Implementation Date:	

State Filing Description:

General Information

Project Name: Group Insurance - Employee Application
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 07/23/2012
State Status Changed: 07/23/2012
Created By: Linda Pawlowski
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: Linda Pawlowski

Filing Description:
SENTRY LIFE INSURANCE COMPANY
NAIC # 169-68810
FEIN # 39-6040276
FORM FILING – GROUP INSURANCE EMPLOYEE APPLICATION
785-502-52 EMPLOYEE APPLICATION

The above referenced new form is submitted for your review.

This new form will be used with our group life, group dental and group disability income insurance products currently on file with your department.

As allowed in the SERFF General Instructions, TOI ML02 is being used for this application filing.

This form will replace the employee application form 785-502-01 approved by your department May 17, 2005 (paper filing).

The purpose of this filing is to:

1. Revise the MIB authorization. Effective 1-1-2013, the Medical Information Bureau will require all members to include language in their MIB authorization that elicits an applicant's express written consent to report information to MIB. Members must use the language MIB provided, or language substantially similar. The MIB authorization appears on page four, above the employee's signature.
2. Expand the beneficiary section of the application by adding fields for the social security number, date of birth, address and phone number for the primary and the contingent beneficiaries.
3. Update the Health Questionnaire section which is completed when evidence of insurability is required.

Cosmetic formatting changes have also been made which has caused the application to expand from a three to a four page form.

Thank you.

Company and Contact

SERFF Tracking #:	*SLIN-128589289*	***State Tracking #:***	***Company Tracking #:***
State:	*Arkansas*	***Filing Company:***	*Sentry Life Insurance Company*
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*		
Product Name:	*Group Dental, Disability Income and Life Application*		
Project Name/Number:	*Group Insurance - Employee Application /*		

Filing Contact Information

Linda Pawlowski, Compliance/Development Specialist
1800 North Point Drive
Stevens Point, WI 54481

linda.pawlowski@sentry.com
715-346-6028 [Phone]
715-346-6044 [FAX]

Filing Company Information

Sentry Life Insurance Company
1800 North Point Drive
Stevens Point, WI 54481
(715) 346-6000 ext. [Phone]

CoCode: 68810
Group Code: 169
Group Name: Sentry Insurance Group
FEIN Number: 39-6040276

State of Domicile: Wisconsin
Company Type: stock company
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

Company	Amount	Date Processed	Transaction #
Sentry Life Insurance Company	$50.00	07/23/2012	61101347

SERFF Tracking #:	*SLIN-128589289*	***State Tracking #:***		***Company Tracking #:***	
State:	*Arkansas*		***Filing Company:***	*Sentry Life Insurance Company*	
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*				
Product Name:	*Group Dental, Disability Income and Life Application*				
Project Name/Number:	*Group Insurance - Employee Application /*				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	07/23/2012	07/23/2012

SERFF Tracking #:	*SLIN-128589289*	***State Tracking #:***		***Company Tracking #:***	
State:	*Arkansas*		***Filing Company:***	*Sentry Life Insurance Company*	
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*				
Product Name:	*Group Dental, Disability Income and Life Application*				
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Disposition

Disposition Date: 07/23/2012
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Name Change Endorsement		Yes
Supporting Document	Address Change Endorsement		Yes
Form	Group Insurance - Employee Application	Approved	Yes

SERFF Tracking #:	*SLIN-128589289*	***State Tracking #:***		***Company Tracking #:***	
State:	*Arkansas*			***Filing Company:***	*Sentry Life Insurance Company*
TOI/Sub-TOI:	*ML02 Multi-Line - Other/ML02.000 Multi-Line - Other*				
Product Name:	*Group Dental, Disability Income and Life Application*				
Project Name/Number:	*Group Insurance - Employee Application /*				

Form Schedule

Lead Form Number: 785-502-52

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved 07/23/2012	785-502-52	AEF	Group Insurance - Employee Application	Initial:	50.500	785-502-52 AR and MA.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

EMPLOYEE
APPLICATION

SENTRY® LIFE INSURANCE COMPANY

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

In order to fairly evaluate your application, we may consult various sources including:

- Statements you make on your application
- Your Employer
- Reports from doctors or medical facilities
- The Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. It will not be released without your authorization except as follows:

- To your doctor if there is a condition you may not be aware of
- To Sentry employees, re-insurers or affiliates when needed to handle your insurance
- As required by law
- To law enforcement when illegal activities are suspected

Sentry Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Sentry Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Medical information will be disclosed only through your doctor.

You may learn the nature of any information Sentry has in its file and how any incorrect information may be corrected by contacting the Office of Consumer Affairs, 1800 North Point Drive, Stevens Point, WI 54481.

NOTICE CONCERNING STATEMENTS IN THE EMPLOYEE APPLICATION FOR YOUR INSURANCE

Please read this Application. Omissions or misstatements may cause an otherwise valid claim to be denied. Insurance will be issued on the basis that all the information shown is correct and true.

Sentry Life Insurance Company • 1800 North Point Drive • Stevens Point, Wisconsin 54481

EMPLOYEE APPLICATION
(Please Print-Use Ink)

Account Number: _____

SENTRY® LIFE INSURANCE COMPANY

☐ Initial Enrollment	Change - Check all that apply: ☐ Add Spouse* ☐ Add Dependent Child* ☐ Name Change* ☐ Other: _____ *Provide information in the section below titled "List all eligible Dependents." Do not use this form to change a beneficiary. Please complete a change of beneficiary form.

Employer Name	Address, City, State, Zip

Employee First Name, Middle Initial and Last Name	Address, City, State, Zip

Date of Birth	Place of Birth	☐ Male ☐ Female ☐ Single ☐ Married and Date of Marriage: ___/___/___
Social Security Number		Phone Number
Number of Hours Worked per Week for this Employer		Occupation with this Employer
Date of Permanent Full-Time Employment with this Employer		Indicate Annual Salary $_____

Indicate the coverage you are applying for:

☐ Life and AD&D ☐ Short Term Disability ☐ Long Term Disability ☐ _____

☐ Dental - Employee ☐ Dental - Employee/Spouse ☐ Dental - Employee/Child(ren) ☐ Dental - Family

List all eligible Dependents - This section is applicable to Dental and/or Dependents Life coverage.

First Name, Middle Initial and Last Name	Relationship	Date of Birth	Social Security Number

Sentry's Use Only	Base Life Class Amt. $ Deps. Life ☐ Y ☐ N	Opt. Life Class Amt. $	STD Class Amt. $	LTD Class Amt. $	Dental Class ☐ sgl ☐ eco ☐ eso ☐ family	PID # Effective Date Initial Date
	☐ Non-Med ☐ Med	☐ Non-Med ☐ Med	☐ Non-Med ☐ Med	☐ Non-Med ☐ Med	☐ Non-Med ☐ Late	

Primary Beneficiary

Name (First, Middle Initial, Last) | Relationship

Social Security Number | Date of Birth

Address, City, State, Zip | Phone Number

If the beneficiary is a trust, complete the applicable fields with the trust information and include the date of trust in the date of birth field.

Note: If you designate two or more beneficiaries, they will share equally in the benefits unless you indicate other directions.

Contingent Beneficiary (Contingent Beneficiaries are only applicable if all primary beneficiaries are deceased.)

Name (First, Middle Initial, Last) | Relationship

Social Security Number | Date of Birth

Address, City, State, Zip | Phone Number

If the beneficiary is a trust, complete the applicable fields with the trust information and include the date of trust in the date of birth field.

Note: If you designate two or more beneficiaries, they will share equally in the benefits unless you indicate other directions.

ACCEPT

Information provided on this application is given to obtain insurance coverage selected and is true and complete to the best of my knowledge. I understand this application will be processed through my employer or group policyholder, or its administrator. I authorize Sentry Life Insurance Company to disclose any information contained in this application, including any health information, to my employer or group policyholder, or its administrator, in connection with the application, underwriting and administration of the coverage. This authorization to disclose information is valid for two (2) years from the date this application is signed. I understand that I may revoke this authorization at any time by writing to Sentry Life Insurance Company, 1800 North Point Drive, Stevens Point, WI 54481. Any information disclosed prior to receipt of the revocation will not be affected. I understand my medical records and information which is Protected Health Information governed by the Health Insurance Portability and Accountability Act, once disclosed to others, may be redisclosed by the recipients and is no longer protected by that Act or the underlying privacy regulations. I understand that the insurance applied for will not be in force unless Sentry Life Insurance Company approves this application. I have received and read the Important Notice required by the Fair Credit Reporting Act and the MIB.

Employee Signature: _____ **Date:** _____

PRINT EMPLOYEE NAME _____

EMPLOYER NAME _____

WAIVER

I have been given a chance to enroll in the insurance plans through my employer with Sentry. However, I decline to enroll for _____. If I apply for this insurance at a later date, I understand that I must furnish, at my own expense, proof of good health. Sentry reserves the right to reject my application.

Employee Signature: _____ Date: _____

PRINT EMPLOYEE NAME _____

EMPLOYER NAME _____

Complete this Page When Evidence of Insurability is Required
Please Initial and Date Any Changed Answers

1) Primary Physician Name: _____ ☐ None
Physician Address: _____
Date of your last visit: _____ Reason/Diagnosis last seen: _____
_____

2) What is your height? _____ Weight? _____

		YES	NO
3)	Have you, during the last five years consulted, been treated or examined by any physician or other practitioner? Give details below.	☐	☐
4)	Have you, during the last five years, undergone any surgical operation or been confined or treated in any hospital, sanitarium or similar institution?	☐	☐
5)	Have you EVER had, been told you have or been treated for: chest pain, heart trouble, high blood pressure, diabetes, cancer, tumor, ulcer, emphysema, asthma, shortness of breath, stroke, sleep apnea, alcoholism, drug abuse, or mental or nervous disorder? (If "YES", underline disease and give details below.)	☐	☐
6)	Do you take any medications? Give details below.	☐	☐
7)	Are you contemplating a surgical operation, diagnostic testing, hospitalization, or any other treatment?	☐	☐
8)	Are you now pregnant? (If "YES", due date _____) ..... Complications or problems with current or past pregnancies: _____	☐	☐
9)	Have you had, been told you had, or been treated for immune system disorders, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐

10) Complete details below (or on an additional signed and dated page) to all questions answered yes:

Question Number	Indicate Illness or Nature of Complaint/Treatment or Medication	Duration From: To:	Current Status	Names & Complete Addresses of Physicians, Hospitals and Clinics

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I AUTHORIZE Sentry Life Insurance Company, its reinsurers or legal representatives to obtain information about me and to make a brief report of my protected health information to the Medical Information Bureau (MIB). Information may be obtained from any licensed doctor, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, MIB or others with knowledge relative to the above purposes. This information will be used to determine my eligibility for insurance.

I AGREE THAT: All statements on this application are true to the best of my knowledge and belief and Sentry, believing them to be true, shall act accordingly. This Authorization is valid for two years from the date below. A copy or fax of this Authorization is as valid as the original.

Employee Signature: _____ **Date:** _____

PRINT EMPLOYEE NAME: _____ EMPLOYER NAME: _____

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Supporting Document Schedules

		Item Status:	**Status Date:**
Bypassed - Item:	Name Change Endorsement		
Bypass Reason:	This item does not apply to this filing.		
Comments:			

		Item Status:	**Status Date:**
Bypassed - Item:	Address Change Endorsement		
Bypass Reason:	This item does not apply to this filing.		
Comments:			